2.4 Projected Patient Days are determined from population estimates, based upon actual patient days and trends shown from prior years.

2.5 DSH Payments are provided in compliance with §1923 of the Social Security Act. The obstetric services requirements under §1923 of the Act do not apply to the RTCs because the facilities did not offer nonemergency obstetric services as of December 21, 1987. The facility must have a Medicaid utilization rate of at least one percent. Eligibility for a DSH payment is established under either the Medicaid inpatient utilization rate criteria or the low-income utilization rate criteria under §1923(b), as follows:

2.51 Medicaid Inpatient Utilization Rate If the ratio of the hospital's Medicaid inpatient days to total inpatient days exceeds the mean for all Minnesota Medicaid enrolled hospitals plus one standard deviation of the mean, a facility may be eligible for a DSH payment.

2.52 Low-Income Utilization Rate DSH payment eligibility may also be calculated by determining the ratio of MA revenues (plus any cash subsidies received by the hospital directly from state and local government) to total revenues (plus the cash subsidies amount).

This ratio is added to the ratio of inpatient charity care charges minus the cash subsidies to total charges. Charity care refers to care provided to individuals who have no source of payment, third party or personal resources. If the sum of the two ratios exceeds .25, the hospital is eligible for a DSH payment.

The RTCs are tested under both methods. The DSH adjustment percentage is determined by subtracting .25 from the facility's actual low income utilization rate. This percentage is multiplied by the total rate to establish the DSH payment. The DSH payment for the RTCs is based on the low-income utilization rate method and is limited by the facility-specific limit of §1923(g) of the Act and subject to the institution for mental diseases (IMD) limit of §1923(h) of the Act.

Following is the detailed formula utilized to calculate the DSH percentage. The most recently settled Medicaid cost settlement is the basis for calculating the DSH percentage. Therefore, for interim rates, the DSH percentage calculations are based on the

cost settlement from the second previous fiscal year (i.e., fiscal year 1992 interim rate DSH percentage is based on fiscal year 1990 settlement). For final rates, the DSH percentage calculations are based on the cost settlement for the previous fiscal year.

2.53 DSH Percentage

(A) MA MI* Patient Revenue: Most recently settled Medicaid cost settlement plus Medicaid receipts for the same year less the amount of any prior year's Medicaid settlement included in the receipts.

(B) Cash subsidies [B(1)- B(2)]:

Because the State absorbs the costs exceeding receipts, Cash Subsidies equals the Cost of MI Programs (1) less Total MI Collections (2):

(1) Cost of MI Programs: Amounts reported as allowable cost for the prior year's Medicaid cost settlement.

(2) Total MI Collections: Total receipts reported, adjusted for Medicaid cost settlement in the same manner as MA MI Patient Revenue (A).

(C) Federal and State Funds [A + B]

(D) Total Revenue [B(2)]

(E) Cash Subsidies [B]

(F) Total Revenue + Cash Subsidies [D + E]

* MI = mentally ill or mental illness

(G) Ratio of Government Funding: Total [C/F]:

The percent of resources provided by federal and state government to supply services to low income clients.

(H) Cost of Charity Care [B]

(I) Cash Subsidies [B]

(J) Net of Subsidies and Charity [H-I]:

Subtracting the Cost of Charity Care (H) from the amount of Cash Subsidies (I) always equals zero.

(K) Total Charges: Total patient days times the total per diem rate.

(L) Percent of Charges Unreimbursed [J/K]

(M) Government Funding + Uncovered Care [G + L]

(N) DSH Percentage [M - .25]

2.6 **Additional DSH Payment** For any federal fiscal year in which the State's DSH allotment under §1923(f) of the Act is not otherwise expended, State-operated inpatient hospital DSH payments are increased as follows:

(A) Except as provided in item (B), the amount of the unexpended DSH allotment is prorated among the State-operated inpatient hospitals eligible for a DSH payment under §2.5.

(B) If the DSH payment in item (A) would cause a facility to exceed its facility-specific DSH limit under §1923(g) of the Act, the amount exceeding the limit is prorated among the remaining facilities. This payment formula is applied until ~~either~~ any of the following occur:

(1) All of the formerly unexpended DSH allotment is expended~~; or~~ .

(2) All of the RTCs have DSH payments that equal their facility-specific DSH limits~~; whichever occurs first~~.

(3) The DSH payments to IMDs exceed the limit established under §1923(h) of the Act.

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Methods and Standards for Determining Payment Rates for
Inpatient Hospital Services Provided in
Regional Treatment Center
Programs for Persons with Chemical Dependency

PURPOSE AND SCOPE:

This attachment describes the methods and standards for determining payment rates for inpatient hospital services for individuals age 65 and older in institutions for mental diseases and for inpatient psychiatric services for individuals under age 21. This description only applies to services provided in chemical dependency units of State-owned facilities.

Payment for these services is currently provided under Minnesota's § 1915(b) Consolidated Chemical Dependency Treatment Fund waiver. The following methodology would be applicable in the event the waiver were not in place and is maintained in the plan for waiver cost comparison purposes.

METHODOLOGY:

Payment rates are determined annually on a cost-related basis using Medicare principles of reimbursement effective immediately prior to October 1, 1983, as specified in *Health Insurance Manual* -15, with the following exceptions.

Interim rates are calculated on a per diem basis for each State fiscal year (July 1 to June 30) for individual treatment programs for chemical dependency. The sum of anticipated allowable costs is divided by the number of projected patient days. This amount is increased by a disproportionate population adjustment (DPA). Interim rates are approved for Medicaid by the Medicare intermediary and settlement is reached at the end of the year.

Final rates are calculated by dividing total allowable costs by in-house patient days. This amount is increased by a DPA.

Costs include salaries, current expenses (fuel, utilities, food, drugs, and other expenses), repairs and betterment, depreciation of buildings and equipment, building bond interest, other capital requirements, and other expenses related to patient care, such as physician and ancillary services, central office support (program supervisory staff), collections

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administration (collections for regional treatment centers), other indirect costs (department personnel, medical director, information systems, and program analysis), and statewide support costs (central payroll, stateside personnel), and other State agency support to regional treatment centers.

Projected patient days are determined from population estimates, based upon actual patient days and trends shown from prior years.

Disproportionate population adjustments are provided for each facility to comply with § 1923 of the Social Security Act. First, the obstetric services requirement under § 1923 of the Social Security Act does not apply to the regional treatment centers because the facilities did not offer non-emergency obstetric services as of December 21, 1987. Second, eligibility for a DPA is established under either the Medicaid inpatient utilization rate criteria or the low-income utilization rate criteria under § 1923(b), as follows:

> Medicaid Inpatient Utilization Rate: If the ratio of the hospital's Medicaid inpatient days to total inpatient days exceeds the mean for all regional treatment centers plus one standard deviation of the mean, a facility may be eligible for a DPA.
>
> Low-Income Utilization Rate: DPA eligibility may also be calculated by determining the ratio of MA revenues (plus any cash subsidies received by the hospital directly from state and local government) to total revenues (plus the cash subsidies amount).
>
> This ratio is added to the ratio of inpatient charity care charges minus the cash subsidies to total charges. Charity care refers to care provided to individuals who have no source of payment, third-party or personal resources. If the sum of the two ratios exceeds .25, the hospital is eligible for a DPA.

The regional treatment centers are tested under both methods. The DPA percentage is determined by subtracting .25 from the facility's actual ratio. This percentage is multiplied by the total rate to establish the DPA. The DPA for the regional treatment centers is based on the low-income utilization rate method, because that is the greater amount.

Following is the detailed formula utilized to calculate the DPA percentage. The most recently settled Medicaid cost settlement is the basis for calculating the DPA percentage.

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Therefore, for interim rates, the DPA percentage calculations are based on the cost settlement from the second previous fiscal year. (i.e., Fiscal year 1990 interim rate DPA percentage is based on fiscal year 1988 settlement.) For final rates, the DPA percentage calculations are based on the cost settlement for the previous fiscal year.

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(A) *MA CD Patient Revenue*: Most recently settled Medicaid cost settlement plus Medicaid receipts for the same year less the amount of any prior year's Medicaid settlement included in the receipts.

(B) *Cash Subsidies* [B(1) - B(2)]: Since the State absorbs the costs exceeding receipts, *Cash Subsidies* equals the *Cost of CD Programs* (1) less *Total CD Collections* (2):

(1) *Cost of CD Programs*: Amount reported as allowable cost for the prior year's Medicaid cost settlement.

(2) *Total CD Collections*: Total receipts reported, adjusted for Medicaid costs settlement in the same manner as *MA CD Patient Revenue* (A).

(C) *Federal & State Funds* [A + B]

(D) *Total Revenue* [B(2)]

(E) *Cash Subsidies* [B]

(F) *Total Revenue + Cash Subsidies* [D + E]

(G) *Ratio of Government: Total* [C + F]: The percent of resources provided by federal and state government to supply services to low income clients.

(H) *Cost of Charity Care* [B]

(I) *Cash Subsidies* [B]

(J) *Net of Subsidies and Charity* [H - I]: Subtracting the *Cost of Charity Care* (H) from the amount of *Cash Subsidies* (I) will always equal 0.

(K) *Total Charges*: Total patient days times the total per diem rate.

(L) *Percent of Charges Unreimbursed* [J + K]

(M) *Government Funding + Uncovered Care* [G + L]

(N) *Disproportionate Population Adjustment Percentage* [M - .25]

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided in the State-owned Minnesota Neurorehabilitation Hospital (MNH)

1.0 PURPOSE AND SCOPE

This attachment describes the methods and standards for determining payment rates for traumatic brain injury services for individuals in the state-owned Minnesota Neurorehabilitation Hospital (MNH), a traumatic brain injury hospital with less than 16 beds.

Minnesota has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

2.0 METHODOLOGY

Payment rates are determined annually on a cost-related basis using Medicare principles of reimbursement as specified in *Provider Reimbursement Manual* - HCFA 15, parts I and II with the following exception that a disproportionate share hospital (DSH) payment adjustment shall be made in accordance with the following:

2.1 **Interim Rates** are calculated on a per diem basis for each State fiscal year (July 1 to June 30) for individual treatment programs for mental illness. The sum of anticipated allowable costs is divided by a disproportionate share hospital (DSH) adjustment. Interim rates are approved for Medicaid by the Medicare intermediary and settlement is reached at the end of the year.

2.2 **Final Rates** are calculated by dividing total allowable costs by in-house patient days. This amount is increased by any DSH.

2.3 **Costs** include: salaries; current expenses (fuel, utilities food, drugs, and other expenses); repairs and betterment; depreciation of buildings and equipment; building bond interest; other capital requirements; and other expenses related to patient care, such as physician and ancillary services central office support (program supervisory staff, collections administration for RTCs, other indirect costs (department personnel, medical director, information systems, and program analysis), statewide support costs (central payroll, statewide payroll), and other State agency support to RTCs.

2.4 **Projected Patient Days** are determined from population estimates, based upon actual patient days and trends shown from prior years.

2.5 **DSH Payments** are provided in compliance with §1923. The obstetric services requirements under §1923 of the Act do not apply to the MNH because the facility did not offer nonemergency obstetric services as of December 21, 1987. The facility must have a Medicaid utilization rate of at least one percent. Eligibility for a DSH payment is established under either the Medicaid inpatient utilization rate criteria or the low-income utilization rate criteria under §1923(b), as follows:

2.51 **Medicaid Inpatient Utilization Rate** If the ratio of the hospital's Medicaid inpatient days to total inpatient days exceeds the mean for all Minnesota Medicaid enrolled hospitals plus one standard deviation of the mean, a facility may be eligible for a DSH payment.

2.52 **Low-Income Utilization Rate** DSH payment eligibility may also be calculated by determining the ratio of MA revenues (plus any cash subsidies received by the hospital directly from state and local government) to total revenues (plus the cash subsidies amount).

This ratio is added to the ratio of inpatient charity care charges minus the cash subsidies to total charges. Charity care refers to care provided to individuals who have no source of payment, third party or personal resources. If the sum of the two ratios exceeds .25, the hospital is eligible for a DSH payment.

The MNH is tested under both methods. The Department chooses the low income utilization rate method where the DSH adjustment percentage is determined by subtracting .25 from the facility's actual low income utilization rate. This percentage is multiplied by the total rate to establish the DSH payment. The DSH payment for the MNH is based on the low income utilization rate method and is limited by the facility-specific limit of §1923(g) of the Act and subject to the institution for mental diseases (IMD) limit of §1923(h) of the Act.

The most recently settled Medicaid cost settlement is the basis for calculating the DSH percentage. Therefore, for interim rates, the DSH percentage calculations are based on the cost settlement from the second previous fiscal year (i.e., fiscal year 1990 interim rate DSH percentage is based on fiscal year